

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington**

To: Chiropractors
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 02-34 MAA
Issued: June 6, 2002

For Information Call:
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From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Supersedes: 01-25 MAA

Subject: Update to the RBRVS and Vendor Rate Increase for Chiropractors

Effective for dates of service on and after July 1, 2002, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2002 relative value units (RVUs);
- The Year 2002 additions of Current Procedural Terminology (CPT™) codes;
- Changes to Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes; and
- A legislatively appropriated one and one-half (1.5) percent vendor rate increase.

Maximum Allowable Fees

In updating the fee schedule with Year 2002 RVUs and clinical laboratory fees, MAA maintained overall budget neutrality. The 2001-2003 Biennium Appropriations Act authorizes this one and one-half (1.5) percent vendor rate increase for MAA fee-for-service programs. The maximum allowable fees have been adjusted to reflect the changes listed above.

Attached are replacement pages 7-10 for MAA's Chiropractic Services for Children Billing Instructions, dated June 2000. To obtain this fee schedule electronically, go to MAA's website at <http://maa.dshs.wa.gov> (click on the Provider Publications/Fee Schedule link).

Bill MAA your usual and customary charge.

* RBRVS stands for Resource Based Relative Value Scale

*CPT codes and descriptions are copyright 2001 American Medical Association.
CPT is a trademark of the American Medical Association.*

Coverage

What is covered?

The Medical Assistance Administration (MAA) will pay only for the following:

- Unlimited chiropractic manipulative treatments of the spine; and
- X-rays of the spine limited to:
 - ✓ A single view when the treatment area can be isolated; and
 - ✓ The cervical, thoracic, and lumbo-sacral (anterior-posterior and lateral) areas of the spine when treatment cannot be isolated.



Note: MAA does not reimburse for the following items under the Chiropractic Services for Children program:

- Therapy modalities such as light, heat, hydro, and physical;
- Any food supplements, medications, or drugs; and
- Any braces, cervical collars, or supplies.

Fee Schedule

The following chiropractic services are allowed only for clients under 21 years of age with a referral from an EPSDT provider. These rates are effective for dates of service on and after July 1, 2002.

**Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT[®] procedure code descriptions.
To view the entire description, please refer to your current CPT book.**

Procedure Code	Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee
Visits			
98940		Chiropractic manipulation	\$16.15
98941		Chiropractic manipulation	22.07
98942		Chiropractic manipulation	28.67
X-Rays			
72020		X-ray exam of spine	14.11
72020	26		4.78
72020	TC		9.33
72040		X-ray exam of neck spine	20.70
72040	26		7.05
72040	TC		13.65

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Chiropractic Services for Children


Procedure Code	Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee
72070		X-ray exam of thoracic spine	\$21.84
72070	26		7.05
72070	TC		14.79
72100		X-ray exam of lower spine	22.07
72100	26		7.05
72100	TC		15.02

Modifiers

- **Professional Component only (modifier 26)** – This modifier identifies the x-ray professional component only. When the professional component (reading and interpretation of the x-ray) is performed separately, the service must be billed along with modifier 26.
- **Technical Component only (modifier TC)** – This modifier identifies the x-ray technical component only. When the technical component (taking of the x-ray) is performed separately, the service must be billed along with modifier TC.
- **Consultation only (modifier 1R)** – This modifier identifies the consultation on x-ray examination only. Pays at the professional component rate.

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Billing

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.
 - The provider must submit claims as described in MAA's billing instructions.
 - MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:
 - ✓ The date the provider furnishes the service to the eligible client;
 - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
 - ✓ The date a court orders MAA to cover the services; or
 - ✓ The date DSHS certifies a client eligible under delayed¹ certification criteria.
 - MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
 - ✓ DSHS certification of a client for a retroactive² period; or
 - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.
-  **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.
- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

¹ **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

² **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.